Plan of Care - Encounter Notes (continued)

Plan of Care by Molly Weaver, RN at 8/1/2017 10:47 PM (continued) Version 1 of 1

Low Risk (HDS score 7-10)
Outcome: Progressing
All UFPs in place. Pt has yellow fall band on & green sign outside door. Fall mat down x1, fall alarm present but off d/t LOW fall score. Pt instructed to call for assistance OOB & as needed to void, stated understanding. HDS: 9. Will monitor.

Electronically signed by Molly Weaver, RN at 8/1/2017 10:47 PM

Attribution Key

Attribution information is not available for this note.

Op Note - Encounter Notes

Op Note by Chad B. Willis, MD at 7/31/2017 5:33 PM Version 1 of 1

Author: Chad B. Willis, MD
Filed: 7/31/2017 5:43 PM
Status: Attested
Cosigner: Ruth L. Thomas, MD at 8/2/2017 8:37 AM
Service: Orthopedic Surgery
Date of Service: 7/31/2017 5:33 PM
Editor: Chad B. Willis, MD (Resident)
Author Type: Resident
Creation Time: 7/31/2017 5:33 PM

Attestation signed by Ruth L. Thomas, MD at 8/2/2017 8:37 AM

I was scrubbed during this procedure. Every step of this procedure was performed by me or under my direct supervision.
Ruth Thomas, MD

Operative Note

Patient Name: Craig A Shipp
Date of Service: July 31, 2017

Pre-Procedure Diagnosis:
Persistent nonhealing plantar diabetic pressure ulcer

Post-Procedure Diagnosis:
Same

Procedure(s) Performed:
Right below-knee amputation

Implants:
None

Specimens:
Amputated right lower leg

Op Note - Encounter Notes (continued)

Op Note by Chad B. Willis, MD at 7/31/2017 5:33 PM (continued) Version 1 of 1

Surgeon(s):
Ruth Thomas, MD
Chad B. Willis, MD

Anesthesia:
General Endotracheal Anesthesia

Clinical History:
46-year-old male who has been battling a right plantar diabetic pressure ulcer for 2 years. The is noted Charcot arthropathy as well. He has been previously evaluated by Dr. Thomas in clinic and given the persistence of this diabetic pressure ulcer he would like to pursue right below-knee amputation.

Details of Procedure:
Patient was met evaluated in the preoperative holding area. His history was reviewed and exam was again performed. There are no significant changes since his last clinical examination. He was informed on what the procedure entailed in all questions were answered. He identified the operative extremity. He was consented for right below-the-knee amputation.

At this point the patient was brought to operating room and placed supine on the operating table. He was induced and intubated by the anesthesia team without difficulty. At this point at tourniquet was applied to the operative leg and the extremity was prepped and draped in the normal sterile fashion.

This marked incisions a flap. We carefully measured our incisions as to accommodate a well-fitting prosthesis. A scalpel was used to cut down the bone throughout the course of the previously drawn incision. A wood handle elevator was used to the periosteum off of the tibia proximal to our cut. The fibula was then identified in an periosteum was cut with a scalpel. 1 cm wood handle elevator was used to elevate the periosteum proximally. At this point a transverse osteotomy through the tibia was performed. We then turned our attention to the fibula where an oblique osteotomy was performed. This point we chose to bevel the anterior edge of the tibia and feathered the course edges. At this point amputation knife was used to cut the remaining soft tissue off down to the distal extent of our posterior flap. Amputation knife was kept adhered to bone throughout the course of this until turning the posteriorly to cut the flap. This the tibial nerve was identified and using traction neurectomy technique. All major vessels were identified tied off with silk ties. Saphenous nerve was identified as well and cut with a traction neurectomy technique.

At this point the tourniquet was let down and lap sponges were compressed into the wound to accommodate hemostasis. After allowing sufficient time for hemostasis lap sponges were taken down there were still bleeding evident in the anterior compartment of the wound as well as the deep posterior compartment. Bleeders were tied off using stick ties. At this point the wound was irrigated once again examined for gross bleeding. Bleeding was deemed to be adequately controlled. Once again the wound was copiously irrigated.

At this point we began our mild basis. O Vicryls were used to pull the superficial posterior compartment over the anterior periosteum of the tibia. At this point subcutaneous layer was closed with 2 O Vicryl. Final

Op Note - Encounter Notes (continued)

Op Note by Chad B. Willis, MD at 7/31/2017 5:33 PM (continued) Version 1 of 1

layer of 3 0 nylon was used to close the skin.

At this point the extremity was cleaned and a sterile dressing consisting of Xeroform with 4x4s and well padded Webril was applied. We then applied a splint to maintain extension of the operative extremity.

At this point the anesthesia team awoke the patient and expected him without difficulty. He was transferred to the postoperative help holding area without complication.

Post-operative Plan:
Patient will be admitted to the Orthopedic surgery Office for prophylactic IV antibiotics as well as monitoring. He will work with our physical therapist to help with that to his amputation. We will round on him daily and be available for any questions he or the family has in the interim.

Complications: None

Electronically signed by Chad B. Willis, MD at 7/31/2017 5:43 PM
Electronically signed by Ruth L. Thomas, MD at 8/2/2017 8:37 AM

Attribution Key

Attribution information is not available for this note.

Consults - Encounter Notes

Consults by Dewayne Sora, LMSW at 8/1/2017 9:21 AM Version 1 of 1

Author: Dewayne Sora, LMSW
Filed: 8/1/2017 9:22 AM
Status: Signed
Service: (none)
Date of Service: 8/1/2017 9:21 AM
Editor: Dewayne Sora, LMSW (Social Worker)
Author Type: Social Worker
Creation Time: 8/1/2017 9:21 AM

SW met with the patient and completed an assessment. He lives with his mother in a house with a rolling & standard walker for DME. Has had HH with Mercy and wants to use again if needed. Prior to this admit the patient was independent in his ALDs and used the walker some for ambulation. No additional needs have been identified at this time. CM will follow this patient through discharge.

Electronically signed by Dewayne Sora, LMSW at 8/1/2017 9:22 AM

Attribution Key

Attribution information is not available for this note.

Consults by Dewayne Sora, LMSW at 8/2/2017 11:34 AM Version 3 of 3

Author: Dewayne Sora, LMSW
Filed: 8/2/2017 11:58 AM
Status: Addendum
Related Notes: Original Note by Dewayne Sora, LMSW (Social Worker) filed at 8/2/2017 11:56 AM
Service: (none)
Date of Service: 8/2/2017 11:34 AM
Editor: Dewayne Sora, LMSW (Social Worker)
Author Type: Social Worker
Creation Time: 8/2/2017 11:34 AM

SW spoke with the patient about going home on IV Abx. He is okay with that arrangement. CM planned to